

NAME \_\_\_\_\_ WEEK ENDING \_\_\_\_\_

## WEEKLY ANXIETY INVENTORY

This form is for indicating the type and severity of panic attacks you experience on each day of the week. The definitions of the 2 types of panic attacks are given below. For each day of the week, determine which of your panic attacks were spontaneous and which were situational, and rate the severity of each attack. For each attack also note the time it began, the length of the attack, where you were when the attack began, whether you were asleep or awake, and the symptoms you experienced.

There are two types of panic attacks:

1. **Spontaneous Panic Attack**

A sudden onset of intense anxiety that occurs out of the blue with little or no provocation.

2. **Situational Panic Attack**

A sudden onset of intense anxiety that occurs while you are in or thinking about a phobic or fearful situation. Situational panic attacks occur predictably in certain situations, in contrast to spontaneous panic attacks.

Each attack should be rated on a 0-10 scale, where 1, 2, & 3 mean mild forms of that type of anxiety; 4, 5, & 6 mean moderate forms of that type of anxiety; 7, 8, & 9 mean severe forms; and 10 means the most severe anxiety of that type that you have ever experienced.

Listed below are the symptoms that correspond to the numbers on the next page.

1. shortness of breath
2. dizziness, unsteady feelings, or faintness
3. palpitations or accelerated heart rate
4. trembling or shaking
5. sweating
6. choking
7. nausea or abdominal distress
8. feelings of unreality
9. numbness or tingling sensations
10. hot or cold flashes
11. chest pain or discomfort
12. fear of dying
13. fear of going crazy or of losing control





Name \_\_\_\_\_ Date \_\_\_\_\_

## PHOBIA SCALES

Below you will find some questions which ask you about situations you may fear and the extent to which you avoid these situations. Use the FEAR SCALE presented below to rate the extent to which you fear the situation, i.e., 0 = not at all to 10 = extremely. Use the AVOIDANCE SCALE presented below to rate the extent to which you will avoid the situation, i.e., 0 = never to 4 = always. Please rate the extent to which you feared the situation or avoided it in the Past Week.

### FEAR SCALE

### AVOIDANCE SCALE

0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4
Not at all		Mildly		Moderately			Markedly		Ex- tremely		Never	Some- times	Often	Very Often	Always

Please generate a list of 5 situations you fear the most and write them in the blank spaces below. After you have done this, rate the extent to which you fear these situations and the extent to which you will avoid them using the FEAR SCALE and the AVOIDANCE SCALE.

### PHOBIAS

### FEAR

### AVOIDANCE

	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4
	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4
	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4
	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4
	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4

Name \_\_\_\_\_

Date \_\_\_\_\_

## PATIENT RATED ANXIETY SCALE (PRAS)

INSTRUCTIONS: BELOW IS A LIST OF PROBLEMS AND COMPLAINTS THAT PEOPLE SOMETIMES HAVE. CHECK (✓) ONE OF THE SPACES TO THE RIGHT THAT BEST DESCRIBES HOW MUCH THAT PROBLEM BOTHERED OR DISTRESSED YOU DURING THE PAST WEEK, INCLUDING TODAY. MARK ONLY ONE SPACE FOR EACH PROBLEM AND DO NOT SKIP ANY ITEMS.

HOW MUCH WERE YOU BOTHERED BY:	0 Not at All	1 A Little Bit	2 Moderately	3 Quite A Bit	4 Extremely	HOW MUCH WERE YOU BOTHERED BY:	0 Not at All	1 A Little Bit	2 Moderately	3 Quite A Bit	4 Extremely
1. Lightheadedness, faintness, or dizzy spells						12. Headaches or pains in neck or back					
2. Rubbery or "jelly legs" sensation						13. Feeling tired, weak, and exhausted easily					
3. Feeling off balance or unsteady as if you would fall						14. Being easily startled by sounds, lights or touch					
4. Difficulty getting your breath or overbreathing						15. Sweating excessively					
5. Skipping or racing of your heart						16. Feeling that things around you are strange, unreal, foggy, or detached from you					
6. Chest pain or pressure						17. Feeling outside or detached from your body or a floating feeling					
7. Smothering or choking sensation or lump in throat						18. Worrying you have a serious physical illness					
8. Tingling or numbness in parts of your body						19. Feeling you are losing control or going insane					
9. Hot flashes or cold chills						20. A fear you are dying or something terrible is about to happen					
10. Nausea or stomach problems						21. Shaking or trembling					
11. Episodes or diarrhea						22. Unexpected waves of depression occurring with little or no provocation					

HOW MUCH WERE YOU BOTHERED BY:	0 Not at All	1 A Little Bit	2 Moderately	3 Quite A Bit	4 Extremely	HOW MUCH WERE YOU BOTHERED BY:	0 Not at All	1 A Little Bit	2 Moderately	3 Quite A Bit	4 Extremely
23. Emotions and moods going up and down a lot in response to changes around you						30. Avoiding situations because they frighten you					
24. Being dependent on others						31. Tension and inability to relax					
25. Having to repeat the same action in a ritual, e.g., checking, washing, counting						32. Anxiety, nervousness, restlessness					
26. Recurrent words or thoughts that persistently intrude on your mind and are hard to get rid of, e.g., aggressive, sexual, poor impulse control						33. Sudden unexpected panic spells that occur with little or no provocation Major Attacks (3+ Symptoms)					
27. Difficulty falling asleep						34. Sudden unexpected spells of symptoms (e.g., those listed above) without full panic that occur with little or no provocation Minor Attacks (1 or 2 symptoms)					
28. Waking up in the middle of the night or restless sleep						35. Anxiety episodes that build up as you anticipate (before) doing something and that are more intense than most people experience in such situations					
29. Nightmares						36. Awaking at night with panic					

Name \_\_\_\_\_ Date \_\_\_\_\_ Weight \_\_\_\_\_

### ADVERSE SYMPTOM CHECKLIST

Below is a list of symptoms people sometimes have. Please read each item. Indicate how bothersome each symptom has been for you in the last 24 hours by circling the appropriate number to the right of the item.

	Not at all	Slight	Moderate	Severe
Headache	0	1	2	3
Constipation	0	1	2	3
Poor Memory	0	1	2	3
Nausea or Vomiting	0	1	2	3
Feeling Drowsy or Sleepy	0	1	2	3
Blurred Vision on Reading	0	1	2	3
Increased Appetite	0	1	2	3
Difficulty Starting Urination	0	1	2	3
Trouble Concentrating	0	1	2	3
Nightmares	0	1	2	3
Difficulty Sitting Still	0	1	2	3
Heart Beat Irregular or Pounding	0	1	2	3
Diarrhea	0	1	2	3
Frequent Need to Urinate	0	1	2	3
Dry Mouth	0	1	2	3
Decreased Appetite	0	1	2	3
Tremors or Shakiness	0	1	2	3
Skin Rash	0	1	2	3
Ringing in the Ears	0	1	2	3
Sweating	0	1	2	3
Faintness or Lightheadedness	0	1	2	3
Poor Coordination (Unsteadiness)	0	1	2	3
Stiffness in Muscles	0	1	2	3
Trouble falling asleep	0	1	2	3
Waking up during the night	0	1	2	3
Waking up too early in the morning	0	1	2	3
Loss of sexual interest	0	1	2	3
Problems with arousal (e.g. in men, erection)	0	1	2	3
Delayed or absent orgasm	0	1	2	3

Now, please read the following list of selected situations people may fear and avoid and rate the extent to which you fear and avoid each of the situations.

<u>SELECTED SITUATIONS</u>	<u>FEAR</u>	<u>AVOIDANCE</u>
1. Going far from home.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4
2. Situations associated with sudden unexpected attacks of panic/ anxiety that occur with little or no cause	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4
3. Traveling on buses, subways, trains, or in cars.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4
4. Crowded places, e.g. shopping, sports events, theatres.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4
5. Large open spaces.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4
6. Feeling of being trapped or caught in closed spaces.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4
7. Being left alone	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4
8. The thought of physical injury or illness.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4
9. Hearing or reading about health topics or disease.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4
10. Eating, drinking or writing in public.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4
11. Being watched or the focus of attention.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4
12. Being with others because you are self-conscious.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4
13. Specific situations other than those listed above that frighten you.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4

Do you fear going distances alone? 1. Yes 2. No  
 If yes, what is the furthest distance you can go alone? How many yards? \_\_\_\_\_ How many miles? \_\_\_\_\_

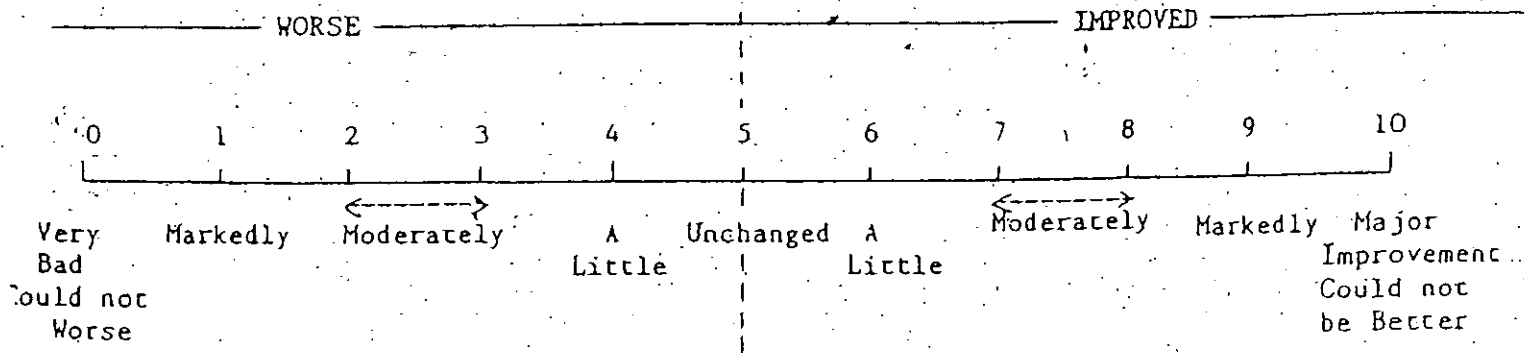
Overall, please rate the present state of your phobias. Use the scale below and circle one number..

0	1	2	3	4	5	6	7	8	9	10
No Phobias present	Mildly Distressing/Restricting		Moderately Distressing/Restricting			Markedly Distressing/Restricting		Extremely Distressing/Restricting		

NAME \_\_\_\_\_ DATE \_\_\_\_\_

### GLOBAL CHANGE SCALE

Since starting this treatment/study my overall progress is:



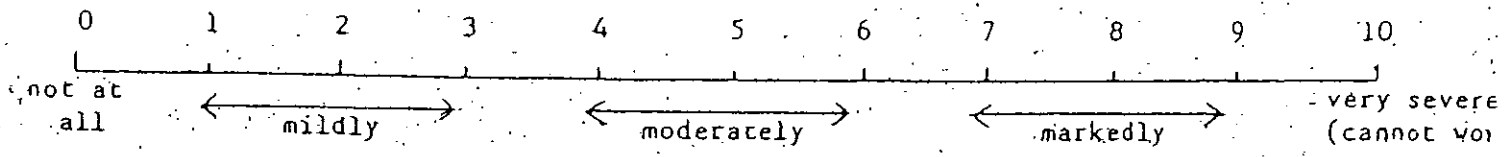
Circle a number that best describes your situation now

NAME \_\_\_\_\_ DATE \_\_\_\_\_

### IMPAIRMENT/DISABILITY SCALES

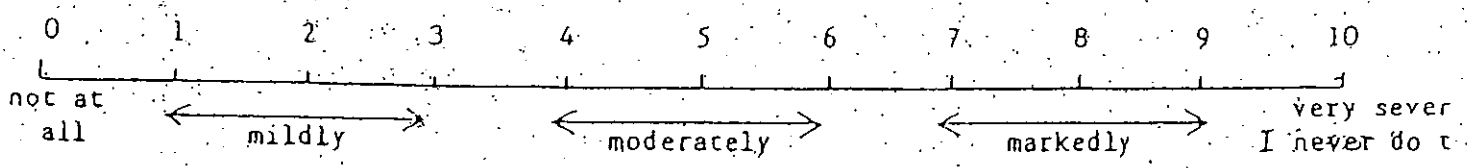
INSTRUCTIONS: CIRCLE A NUMBER THAT BEST DESCRIBES YOUR SITUATION NOW

*school*  
BECAUSE OF MY PROBLEMS MY WORK IS IMPAIRED



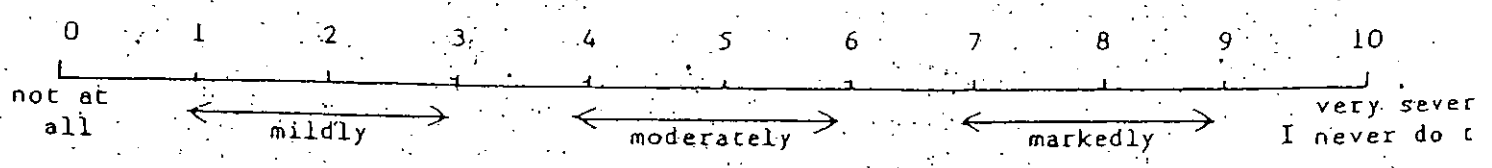
SOCIAL LIFE/LEISURE ACTIVITIES  
(with other people at parties, socializing, visiting, dating, outings, clubs, entertaining)

BECAUSE OF MY PROBLEMS MY SOCIAL LIFE/LEISURE IS IMPAIRED



FAMILY LIFE/HOME RESPONSIBILITIES  
(relating to family members, paying bills, managing home, shopping, cleaning)

BECAUSE OF MY PROBLEMS MY FAMILY LIFE/HOME RESPONSIBILITIES ARE IMPAIRED



OVERALL, BECAUSE OF MY PROBLEMS MY LIFE IS IMPAIRED

